Our Ref: C22.7292
Your Ref: 18780099

04 July 2024

Humber Health Partnership
**Hull Royal Infirmary**
Anlaby Road
Hull
HU3 2JZ

Tel: [redacted]
Email: [redacted]

Sally Robinson
Assistant Coroner for Hull & the East Riding of Yorkshire
The Coroner's Court & Offices
The Guildhall
Alfred Gelder Street
Hull
HU1 2AA

Dear Ms Robinson,

**Inquest – Linda Heath Deceased – Response to Regulation 28 Report to prevent future deaths**

The Trust is in receipt of the Regulation 28 Report issued by yourself at the conclusion of the inquest you held regarding the death of Linda Heath who died in March 2022. This is the response of Hull University Teaching Hospitals NHS Trust.

It was understood by the Trust following the Inquest that there was an agreement that an update would be provided by the Trust on the measures already being taken which relate to the concerns raised by the Coroner. Therefore please can we request clarification as to whether the Coroner requires any further update beyond those provided in this response? If a response is also being sought from the national organisations listed at point 1, please could any responses provided be shared with the Trust?

Matters of concern at paragraph 5 of the Report are noted, and the Trust responds as it did at the Inquest in relation to points 1 and 4. Points 2 and 3 relate to primary care.

The first matter of concern relates to the immediate discharge summary not including relevant or sufficient information about the required treatment in the community or a nursing summary of care needs. This issue was canvassed extensively during the course of the inquest process. The Trust indicated that it would keep the Court advised as to progress to address issues which arise from the fact that a referral to district nursing upon Linda Heath's discharge in February 2022 was not made. The problem here is the failure to make the referral, not the failure to refer to this issue in the immediate discharge summary as it

would not be for primary care to make the referral. The Trust has concentrated its efforts in seeking to address the core problem and reduce the risk of referrals to community services being missed, as happened here, at the point of discharge from hospital.

The Trust confirms that it has developed a pro forma to be utilised by nursing staff in relation to each and every discharge of an in-patient. This pro forma will be used when nurses are planning for a patient's discharge, and it will identify and highlight a number of matters that need to be considered and addressed at the point of discharge. The pro forma is still being finalised, this work is expected to conclude within the next two weeks – because it is an electronic system, the Trust's digital team has been involved in updating it. That said a number of wards are already using the document in paper form but this will be rolled out across the Trust very shortly. The pro forma will have a specific prompt to nursing staff to remind them to consider whether a referral to community nursing is required, and the form will also require them to insert details of to whom the referral has been made. Therefore in an equivalent case to that of Linda's now this form would be completed by a nurse as plans for discharge are being made: the prompt on the form would remind staff of the need to consider whether a referral needs to be made to community nursing, and the form requires staff to complete information as to whom the referral has been made. This should serve to reduce the risk that necessary referrals that need to be made upon a patient's discharge are overlooked.

In relation to the immediate discharge summary this is a document completed by medical staff, and is intended to be a summary of the medical care. There are ongoing discussions about the level of information that should be included within the form, as it is important it does not become too lengthy, but the Trust is of the view that in order to prevent the problem that occurred in Linda's case, the issue to be addressed is ensuring that appropriate referrals are made in the first place, by the Trust at the point of discharge. In Linda's case if the discharge summary had noted the need for community nursing referral it is true that it is possible the GP could have followed this up, but in fairness it would not be the GP's responsibility to do that. In Linda's case she proactively sought input from her GP and their involvement was discussed at the Inquest.

The other issue of concern relevant to the Trust's involvement (point 4) related to an over-reliance upon private hygiene care packages with insufficient enquiry into the parameters of care provided by the private domiciliary carers. At the point of discharge, patients who are in receipt of care packages at home need

to have them reinstated. Staff are being reminded of the need to consider whether the packages may require revision and re-assessment, as a result of whatever has brought the patient into hospital, and if such is required an appropriate referral usually to Social Services will be made.

It is also worth noting that the Trust has seen the response prepared by CHCP in relation to the Regulation 28 report and, in particular, note their comments regarding the triangulation meetings taking place in relation to complex Tissue Viability Nursing (TVN) cases. The Trust confirms that the system is working well in terms of improving liaison and communication between Acute Hospital TVN teams and the CHCP Community District Nursing Team in Hull that provide community nursing services. Plans and discussions are under way to establish similar processes for community providers in other parts of the Trust's geographical area including North & Northeast Lincolnshire.

We trust this responds to the matters raised within the prevention of future deaths report.

Yours faithfully

[redacted]

[redacted]

**Group Chief Nurse**